

SERFF Tracking Number: LFCR-126302024 State: Arkansas
Filing Company: Assurity Life Insurance Company State Tracking Number: 43491
Company Tracking Number: ALAR-AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Assurity Balance
Project Name/Number: /

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: Assurity Balance

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: LFCR-126302024 State: Arkansas

SERFF Status: Closed-Approved State Tr Num: 43491

Co Tr Num: ALAR-AR State Status: Closed

Reviewer(s): Harris Shearer

Authors: Smith Darlene, Trudy Weigel Disposition Date: 09/21/2009

Weigel

Date Submitted: 09/11/2009 Disposition Status: Approved

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/21/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/21/2009

Created By: Smith Darlene

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Smith Darlene

Filing Description:

RE: ASSURITY LIFE INSURANCE COMPANY - NAIC # 71439

Long Term Care filing of Tax-Qualified Policy Form ALAR-AR, Application for Reinstatement of Long Term Care Insurance

The above referenced form is being filed for your review and approval. This application will be used in conjunction with our Long Term Care Policy, AL2100P-AR as approved by the Department on August 20, 2007, and State tracking number 35181, SERFF tracking number LFCR-125113757.

Concurrent with this filing, this form is being filed in the Company's domiciliary state, Nebraska.

Thank you for your assistance with this filing.

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Company and Contact

Filing Contact Information

Trudy Weigel, Compliance Analyst 2 trudy.weigel@lifecareassurance.com
 P.O. Box 4243 818-867-2240 [Phone]
 Woodland Hills, CA 91365-4243 818-867-2508 [FAX]

Filing Company Information

(This filing was made by a third party - LCA01)

Assurity Life Insurance Company CoCode: 71439 State of Domicile: Nebraska
 Long Term Care Administrative Office Group Code: 3910 Company Type:
 P.O. Box 4243 Group Name: Assurity Security Grp State ID Number:
 Woodland Hills, CA 91365-4243 FEIN Number: 38-1843471
 (818) 867-2450 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form/1 form filed
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	\$20.00	09/11/2009	30497399

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	09/21/2009	09/21/2009

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Disposition

Disposition Date: 09/21/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	AR Certificate of Compliance		Yes
Form	Application for Reinstatement of Long Term Care Insurance		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ALAR-AR	Application/ Enrollment Form Application for Reinstatement of Long Term Care Insurance	Initial			ALAR-AR.pdf

**APPLICATION FOR REINSTATEMENT
OF LONG TERM CARE INSURANCE**
(PLEASE PRINT)

Assurity Life Insurance Company
Home Office: Lincoln, Nebraska
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
(888) 505-3980

POLICY NO. 18-12345678
ALAR-AR

Applicant Information	① Policyholder (First Name, Middle Initial, Last Name) <i>John Doe</i>	Height <i>6' 0"</i>	Weight <i>180</i>	Birthdate <i>7-1-53</i>	Age <i>55</i>
	② Joint Policyholder (If Joint Coverage) <i>Mary Doe</i>	Height <i>5' 5"</i>	Weight <i>130 lbs.</i>	Birthdate <i>7-1-58</i>	Age <i>50</i>
	Address <i>123 Main St.</i>			Phone Work: <i>(555) 555-1212</i> Home: <i>(555) 555-1212</i> Cell/Other: <i>(555) 555-1212</i>	
	City, State, Zip <i>Anytown, ST 12345-6789</i>			Acceptable times to call: <input checked="" type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Sat/Sun	

Health Questions	HEALTH QUESTIONS - Complete for both ① Policyholder and ② Joint Policyholder (If Joint Coverage).					
	1. During the past 2 years, have you been confined to a hospital, nursing facility, home for the aged or any other care facility; or has a doctor recommended such confinement or the services of a trained attendant in your place of residence? <input type="radio"/> Yes <input checked="" type="radio"/> No ② <input type="radio"/> Yes <input checked="" type="radio"/> No					
	2. Do you need assistance or supervision for everyday activities such as cooking, dressing, eating, housekeeping, bathing, toileting, shopping or walking? <input type="radio"/> Yes <input checked="" type="radio"/> No ② <input type="radio"/> Yes <input checked="" type="radio"/> No					
	3. Are you confined to a bed; or do you use a wheelchair, walker, braces, or cane; require kidney dialysis or use oxygen equipment? <input type="radio"/> Yes <input checked="" type="radio"/> No ② <input type="radio"/> Yes <input checked="" type="radio"/> No					
	4. During the past 10 years, have you been medically advised or treated for: (a) Alzheimer's disease or dementia; (b) Amyotrophic Lateral Sclerosis; (c) Parkinson's disease; (d) brain disorder; (e) systemic lupus; (f) cirrhosis of the liver, or (g) alcohol or drug dependency or abuse? <input type="radio"/> Yes <input checked="" type="radio"/> No ② <input type="radio"/> Yes <input checked="" type="radio"/> No					
5. During the past 5 years, have you been medically advised or treated for: (a) cancer; (b) diabetes; (c) arthritis or osteoporosis; (d) high blood pressure, heart disorder, stroke or TIA, or circulatory system disorder; (e) emphysema or other respiratory disorder; (f) kidney disorder; or (g) depression or nervous system disorder? <input type="radio"/> Yes <input checked="" type="radio"/> No ② <input type="radio"/> Yes <input checked="" type="radio"/> No						
Provide full details below for any "Yes" answer. Indicate Policyholder ① or ②.						
	Pol. ① or ②	Ques. No.	From Date	To Date	Describe Condition, Treatment and Medication Prescribed	Name and Address of Doctor or Care Facility

Representations of the Policyholder(s)	CAUTION: If your answers on this application are incorrect or untrue, Assurity Life Insurance Company has the right to deny benefits or rescind your policy.					
	AGREEMENT - The answers given are complete and true to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in this reinstatement application and that if my answers are not complete and true, my policy may not be valid.					
	ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO ASSURITY LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO AGENT OR LEAVE PAYEE BLANK.					
	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.					
	Signed at <u>Anytown, ST</u>		<u>John Doe</u>		<u>8-1-08</u>	
	City, State		Policyholder's Signature		Date	
	<u>John Q. Porter</u>		<u>Mary Doe</u>		<u>8-1-08</u>	
	Agent's Signature		Joint Policyholder's Signature		Date	
	<u>1234</u>					
	Ident. Code					

Conditional Receipt	ASSURITY LIFE INSURANCE COMPANY		
	Policy number <u>18-12345678</u> Premium \$ <u>1,916.12</u> received from <u>John Doe</u>		
	It is understood and agreed that payment is accepted subject to completion and return of the attached reinstatement application. The Company assumes no liability by the issuance of this receipt unless and until reinstatement is approved. We will notify you of approval or disapproval within 45 days of the date of this receipt. If your application is disapproved the amount submitted will be returned to you.		
	<u>8-1-08</u>	By: <u>John Q. Porter</u>	<u>1234</u>
Date	Agent or Company Representative	Ident. Code	
POLICYHOLDER — Retain this receipt for your records.			

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification Bypass Reason: N/A Comments:		
Bypassed - Item: Application Bypass Reason: N/A Comments:		
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:		
Satisfied - Item: AR Certificate of Compliance Comments: Attachment: AR Certificate of Compliance.pdf		

CERTIFICATION OF COMPLIANCE

Insurer: _____

The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Signature: _____

Name: _____

Title: _____

Date: _____